IN THE DISTRICT COURT OF THE UNITED STATES

FOR THE EASTERN DISTRICT OF MICHIGAN

SOUTHERN DIVISION

JAROSLAW WASKOWSKI,

Plaintiff,

vs. Civil Action

No. 11-CV-13036

HON. MARK A. GOLDSMITH

STATE FARM MUTUAL AUTOMOBILE INSURANCE COMPANY,

MAG. JUDGE HLUCHANIUK

Defendant,

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The Videotaped Deposition of

STEVEN R. GEIRINGER, M.D.,

Taken at 36301 Warren Road,

Westland, Michigan,

Commencing at 12:49 p.m.,

Wednesday, November 21, 2012,

Before Dale E. Rose, CSR-0087.

APPEARANCES:

MR. LEE ROY H. TEMROWSKI, JR. (P31967)
Temrowski & Temrowski
45109 Van Dyke Avenue
Utica, Michigan 48317
(586) 254-5566
Appearing on behalf of the Plaintiff

MR. JAMES F. HEWSON (P27127)
Hewson & Van Hellemont, P.C.
25900 Greenfield Road, Suite 328
Oak Park, Michigan 48237
(248) 968-5200
hewson@vanhewpc.com
Appearing on behalf of the Defendant

ALSO PRESENT:
MARC MEYERS, Videographer

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Westland, Michigan
Wednesday, November 21, 2012
About 12:49 p.m.

VIDEOGRAPHER: We are now on the record. This is the videotaped deposition of Dr. Steven Geiringer being taken in Westland, Michigan. Today is Wednesday, November 21, 2012, the time is now 12:49 PM.

And at this time will the attorneys please state your appearances for the record and the court reporter please swear in the doctor.

MR. TEMROWSKI: Lee Temrowski appearing on behalf of Mr. Waskowski.

MR. HEWSON: James Hewson appearing on behalf of State Farm.

STEVEN R. GEIRINGER, M.D.,

having first been duly sworn, was examined and testified on his oath as follows:

MR. HEWSON: The record should reflect that this is the day and date set for the taking of the deposition of Dr. Steven Geiringer pursuant to Notice and further pursuant to the Federal Rules of Civil Procedure, and the deposition is being taken in lieu of the doctor's live appearance at the time of trial.

EXAMINATION

BY MR. HEWSON:

Q. Dr. Geiringer, for the record would you identify yourself and give us your professional address?

A. Steve Geiringer, 36301 Warren Road in Westland.

Q. And what is your profession, sir?

A. I'm a medical doctor.

Q. And how long have you been a medical doctor?

A. 1979, so 33 years.

Q. Do you have a specialty?

A. I do, physical medicine and rehabilitation.

Q. Could you tell the jury what the specialty of physical medicine and rehabilitation entails?

A. That field is pretty much split into two, the physical medicine and then the rehab.

And the rehab side people might be more familiar with if someone's had a stroke or spinal cord injury, has MS, something like that. The rehab doctor will oversee all of the therapies and medications and treatments and try to get the person back hopefully as much as possible function-wise.

I practice on the physical medicine side which deals with musculoskeletal injuries, sprains or strains, ruptured disks, pinched

nerves, making the diagnosis mostly by exam or testing and then overseeing treatment, therapy, medications, sending somebody for injections and hopefully get them back to Square 1, if not as much as possible.

DEPOSITION EXHIBIT 1
curriculum vitae of deponent
WAS MARKED BY THE REPORTER
FOR IDENTIFICATION.

Q. Thank you. I've marked as Exhibit 1 your curriculum vitae and I'd ask you just to take a quick look at that, tell me if it's accurate and up to date as of today's date?

A. Pretty much. All the background information is the same. This is dated July, 2011 so there would only be a few additional presentations and things like that, but otherwise it's up to date.

Q. Thank you. So the record is clear, this is 33 pages long, am I correct?

A. Yes.

Q. Rather than taking you through all 33 pages let me hit a few of the highlights. Are you presently affiliated with any hospitals?

A. No.

Q. And are you presently teaching anywhere?

A. I am a clinical professor at Wayne State University.

Q. What does being a clinical professor mean?

A. In medicine it's different than being a professor in some other fields where's there's classroom teaching and things like that.

For me, for physicians it means when I go around the country to make presentations I'm there pretty much representing Wayne State as part of their faculty. So, an example, I just came back Saturday from our national -- yearly national meeting and had a couple presentations in that forum and it's through Wayne State that -- I've represented as through Wayne State.

Q. You are board certified in your specialty, is that correct?

A. Yes.

Q. And can you tell the jury how one becomes board certified?

A. Well, it's really a process starting with where you do your training, your specialty training, and my field of PM&R is one of the 24 major specialties, so all these fields you have to go to a program that itself is allowed to turn out board certified people or potentially.

Every year along the way the person supervising you has to say yep, ready to move on to the next step. At the end of training that person has to say ready to sit for the exam.

In my field the initial certification is a two-year process, that year and the year after. And nowadays it's not just a one-time thing any more. You have to what's called maintain certification, so every year on an ongoing basis there are things, continuing education and all sorts of other things that has to be done to maintain certification.

Q. What does "board certification" mean?

A. Well, it's the only measure we have that somebody has attempted to take those steps and has succeeded in taking those steps that are meant to show that somebody is able to practice competently.

There's really nothing else in the field of medicine that one can turn to other than board certification.

Q. I know this is an obvious question, but you are licensed in the state of Michigan to practice?

A. Well, you have to be to be board certified, so yes.

Q. Thank you. Now, in your curriculum on Page 3 you mention affiliations with University of Michigan Hospital, Rehab Institute of Michigan.

What do those affiliations mean?

A. Those were hospital or medical center affiliations when I was on the staff of those two organizations. After I finished my training in '82 I joined the faculty at Michigan and the staff of the medical center until '91 at which point I moved to Wayne State's faculty and the clinical staff of the Rehab Institute which is part of the Detroit Medical Center.

In '99 I went into solo private practice, so left the Rehab Institute DMC but still maintained the academic professor appointment at Wayne State.

Q. Now, you mentioned that you went into private practice in 1999. How much of your time is taken up with your private practice, not just the examinations that -- such as you did with Mr. Waskowski, how much of your time is taken up with your private stuff?

A. You mean treatment?

Q. Yes, sir.

A. Because it's all part of my private practice all

rolled in together, but the treatment side is about 60 percent.

Q. And in Mr. Waskowski's case, how did he come to be seen by you, if you know?

A. He apparently was sent to me by what I call like a broker company that arranges for these evaluations to be done called MES.

Q. How long have you taken patients or gotten individuals for examination from MES, if you know?

A. Oh, I think since soon after I went into practice, so meaning '99.

Q. Can you tell me what if any way your examination would differ from one of the patients in your private practice and one of the patients you examine, for example, through an MES referral?

A. Again, I assume you mean a treatment patient as opposed to someone I'm seeing for evaluation only?

Q. Yes, sir.

A. There's no actual difference in terms of everything I do, the interview, asking them about their situation and the examination is identical.

One typical logistical difference is that folks I'm seeing for evaluation only often

have a file of records that doesn't exist with somebody I'm seeing for treatment simply because when I treat somebody it's usually pretty quick, a work injury or car accident within the past short time, a few weeks or something.

So if there's any records, it might be an x-ray or something as opposed to if someone -- for example, with Mr. Waskowski his car accident was a year and a half before I saw him and there were a couple of inches of records sent to me.

Q. Now, as you said in patients that are here to be treated by you, even if the prior medical history or medical records were brief you would normally get those as part of your treatment of that patient?

A. Well, it's always helpful for a physician to know what has already happened, if there's been any kind of imaging, x-rays or MRI scans, if they've been through treatment, therapy, whatever, yeah, it's always good to have those.

Do I always get them ahead of time, no. Then I request them for afterwards, but it allows you to focus your exam and your questions maybe a bit more on certain areas than others when you know what the main problem has been all along.

Q. Now, you also have, I believe, a specialty in electrodiagnostic medicine, is that true?

A. Right, that's sort of a sub-board certification, right.

Q. And was the process the same to obtain that board certification as you described relative to your specialty in physical medicine?

A. It is what I would call a secondary board certification so it's not one of the primary fields of specialty. My field, pediatric surgery, that sort of thing, it is secondary and electrodiagnostic medicine has to do with a test called EMG and all the medicine that sort of surrounds that.

EMG is used in my field mostly to diagnose pinched nerves. Other fields might be muscle diseases or Lou Gehrig's disease, things like that in neurology.

But in my field it's mostly to diagnose pinched nerves like coming from the neck or back or like carpal tunnel, things like that.

Q. This may seem like a simplistic question, so please forgive me, but is the EMG a recognized diagnostic tool for physicians?

A. Yes. I mean there's an entire organization that

has to do all with the field of medicine that surrounds EMG. There's a board certification examination about -- I think about 1,200 or 1,500 people in the country are certified in EMG. It's a very well recognized study. It's been around since about the '50s and it got into more prevalence in the '60s and '70s and of course now it's very well recognized.

Q. And it wouldn't fall under the category of a test that has no medical foundation and is only there to line the pockets of the physicians that order EMGs, right?

A. Would EMG be considered that?

Q. Yeah.

A. No. I mean, EMG is a very well known and very well accepted and respected test when done correctly. Like every test, I suppose based on your question could someone do unnecessary EMGs, sure, like you can do unnecessary x-rays or anything else.

But no, it's a very well recognized and highly researched -- very highly researched study, exam.

Q. So I want you to assume for the sake of this next question that Dr. Glowacki said this is a lousy

test, an EMG, that has no real value clinically.

Would you agree with that statement?

A. No, not at all.

Q. What is the first thing you do when you examine a patient?

A. In the room the first thing after introduction is to take a history which is basically an interview. On the typical symptom for people I see whether I'm treating them or not the most common symptom is pain, pain, numbness, tingling, weakness.

So you ask them what happened. In this case it was a car accident, but you ask them what they're feeling basically, do they have pain, where is it, what makes it better, what makes it worse, what treatments have you had, does it make it better or worse, all those sorts of things.

Have you had prior such problems or is this new since -- in this case it's the car accident.

Q. When was the first time that you saw Mr. -- I'm sorry, I believe it was the only time that you saw Mr. Waskowski?

A. It was the only time, that was July 7 of 2011, not quite the year and a half ago.

Q. And what did he tell you relative to that historical inquiry?

A. He said he was operating his vehicle, was hit on the driver's side. He had symptoms in multiple areas. He was very clear that he was getting slowly worse as time went by. And then I ask people was there ever a time that you got a whole lot better but then something happened and you went south again.

No, he was very clear he had never improved even temporarily. He had low back pain that was in the middle and off to his left, not on the right. He had pain down the left thigh, through the left thigh toward the knee.

He then had neck pain also more on the left and all the way down the left arm to the wrist, and either wrist would sometimes swell, but more on the left.

So all of his sympt -- almost 100 percent of his symptoms were on the left.

Q. Were you able to observe any swelling in his wrists during your examination?

A. When I examined him there was no swelling, no.

Q. What history did he give you, if any, relative to his treatment that he had received?

A. He said he was seeing -- you mentioned Dr. Glowacki. He was seen by Dr. Glowacki. He had been in physical therapy three times a week. When I saw him it had been one and a half years since the accident and he told me he had been in therapy that entire time.

He mentioned modalities, what we mean like hot packs or things like that, ultrasound and exercise. Said he was doing exercises very regularly at home and that he was taking Vicodin for pain.

Q. In that connection is Vicodin the drug of choice I guess you would inartfully say for a person with what would be soft tissue injuries?

A. Well, Vicodin as it turns out is what is called an opiate medication, an opiate narcotic. And opiates have shown over the years and increasingly lately, more and more studies as time goes by, that they absolutely should not be used for chronic conditions because people do actually worse function-wise, function day by day, returning to work is worse with chronic opiates, and there's more and more evidence now that in fact they don't even make a noticeable difference in pain levels.

People tend -- and in my office too -- people tend to say well, you know, they helped short term, but you really want to keep opiates for more serious problems that are short term, certainly not for long term.

And general consensus or standards of practice would say that you don't use them for soft tissue strains.

Q. If medication is indicated on a person with soft tissue injuries, what medication do you recommend?

A. Typically it would be just an over-the-counter like Extra Strength Tylenol. Tylenol has been shown to be as effective as the antiinflammatories, but without the GI possibilities of GI distress.

An antiinflammatory like Motrin or Advil, something like that, Naprosyn, typically we're not talking about an actual inflammation situation, not usually.

For an acute ruptured disk there might be, so you might use antiinflammatories. For a soft tissue strain it's just the pain, so Tylenol is really quite effective. There's others like Ultran. By research studies if they're at all

more effective than plain Tylenol or Extra Strength Tylenol, not by much.

Q. You mentioned that Mr. Waskowski gave you a history of physical therapy?

A. Yeah.

Q. You order physical therapy I assume for your patients?

A. Sure.

Q. When you're evaluating a patient for physical therapy what kind of concerns -- I'm sorry -- what do you express to the physical therapist as to what you're looking for if you're specific when you're dealing with them?

A. Well, physical therapy is done for people who have an actual impairment or a condition that explains their symptoms and I would tell the therapist what the symptom is or what the condition is, what the diagnosis is.

And it depends on the therapist. There are a few therapists who I've sent people to for literally 20 years and I know that he or she knows exactly what I ask for, so I ask for the generalities, manual therapy, stretching, mobilization, that sort of thing.

If it's a therapist at a facility I

don't know I give them much more detail than that.

Q. You mentioned diagnosis. What is "diagnosis", what is that?

A. Well, it's an actual condition so if somebody has, let's just say, back pain, that's a symptom. That doesn't tell you what's causing the back pain, but that will prompt the physician to look for what's causing the back pain, a muscle strain like muscle pull, ruptured disk, pinched nerve, whatever it might be.

That's the diagnosis, the actual condition that's causing your symptoms.

Q. Pain you said is a symptom, am I correct?

A. Yes.

Q. I've heard the word "subjective" versus "objective", objective signs or findings and subjective symptoms.

Could you tell the jury what the difference is between those things?

A. Anything that is a symptom that someone tells me they're feeling the pain, the numbness, the tingling, that is subjective. That is -- it goes through their brain and they have to interpret it. It's not something I can measure.

So someone says their back hurts a little or a lot, it hurts 9 out of 10 or 1 out of 10, there's no machine that can measure pain. There's really no machine that can measure numbness or other things either. Those are all subjective.

Then it's up to the physician to look for something that correlates with that, something objective. So if I bend the person forward and their back goes into a big twist or a torque, that's objective. That's not within their control.

If I measure their calves because they might have a pinched nerve and one calf is half an inch smaller than the other and that goes along with a reflex that's down on the same side, the ankle, you know, tap with the reflex, those things are not in the person's control.

Those are measurable, those should be reproducible from one person to the next if the test has been done correctly. Those are objective.

Q. Was it your understanding from the history Mr. Waskowski gave you that he had been in physical therapy for the entire period of time

from the accident up until the time he saw you?

A. He did, he said one and a half years which was pretty much exact amount of time -- I guess when I saw him -- yeah, it was a couple of weeks more than 1.5 years.

Q. What if -- are there any standards for the prescription of physical therapy that you deal with in your specialty, that is as to length of time and that sort of thing?

A. Sure. There are general sort of consensus opinions and there is something called the ODG, which stands for official disability guidelines.

For a strain, for a muscle pull, they would allow 10 visits, the ODG would. And then you have to go from there. If it's helping a lot -- you know, in my mind if I see somebody back in three weeks which is about eight or 10 visits and it's helping a lot, yeah, I'll give them another couple or three weeks maybe, a couple of weeks, see them back.

I've seen some physicians who I respect will say maybe two months even or something like that and the ODG, as I mentioned, would be 10 visits. Those are some guidelines for soft tissue strains.

Q. What do you as a specialist in physical medicine and rehabilitation do if the first 10 visits aren't working or if the person is getting worse? What do you do relative to physical therapy?

A. Well, there's two possibilities. One is that perhaps the physical therapist, the person they're seeing, there are certain techniques that not all therapists are trained in and maybe that person is the wrong therapist.

But typically therapists are -- you know, if they're doing what they're supposed to do and you've gone three weeks -- I allow three -- that's why I see people back after three weeks of therapy. After three weeks which is eight or nine visits, it's not going to suddenly change so you have to pretty much think, well, you know, maybe I have the wrong diagnosis or who knows what. So you got to change something.

In fact, there are physical therapy standards of practice within their own field. Their standards say that if therapy is ineffective you, the therapist, must discuss this with whoever ordered the therapy and alter something, do something different.

Q. And writing "pain" on a prescription form does

not suggest any diagnosis if that's the only "diagnosis" on that piece of paper, am I correct in that?

A. Pain from the standpoint of can you find a diagnosis code in the book that -- you know, the CPT code, you can find a diagnosis code for pain, but medically it's not a diagnosis, it's a symptom.

The diagnosis would be, for example, lumbar strain in a muscle pull or herniated disk, ruptured disk, so pain is not medically a diagnosis.

Q. After you conclude the history portion of your examination did you -- what do you do next or what did you do in regard to Mr. Waskowski?

A. What I do in my office is leave the room, have them change into a gown while I dictate the first portion that we just talked about, the history.

Then I go back into the room and examine the person, do the physical examination.

Q. And could you tell the jury what your physical examination of Mr. Waskowski included?

A. Now, do you want to have me give you the general exam and then --

Q. If you wouldn't mind, if you can tell us the

general exam and then I'll ask about specific findings?

A. Okay, all right. The general exam is split into two parts, what I call the musculoskeletal and then the neurologic. The musculoskeletal, for example, would look mostly for muscle pulls or muscle strains, so things like in the low back -- and these all translate kind of to the neck too.

But in the low back having the person move around in six different directions, does it hurt, where does it hurt, which motions make you feel better, which make you feel -- the back feel better or worse, that sort of thing. Is the back motion even and smooth or is there a torque or a twist on the back like I kind of mentioned before, which means the muscles are more tight on the one side than the other.

Palpation which is basically pushing over the muscles where the muscles attach, where nerve runs through, that sort of thing, does it hurt. And if it does hurt, if the muscles are tight for even a few weeks, certainly a month or more, they feel abnormal.

People describe like a twine, a ropy kind of feeling, orange peel, orange rind or

something, but they feel abnormal to the experienced fingers; look for that.

The neurologic is basically looking for -- the other half of the exam -- basically looking for a pinched nerve, so running from the back down the leg or from the neck down the arm. Tapping on the reflexes with the hammer, testing strength, push against me or squeeze my fingers, is there a difference from side to side.

Atrophy meaning if there's been a pinched nerve -- nerve damage to a muscle that calf might be smaller, the thigh might be smaller depending on which nerve. Sensation, can you feel the touch or the pin, whatever you use, the same on one side or the other and if you can't, if it's different on one side, is it pretty close to a typical what we know as a nerve distribution, a nerve pattern, or not.

Q. Thank you. You went through all of that physical examination with Mr. Waskowski, am I correct?

A. Yes.

Q. Can you tell the jury what if any findings you made that you considered significant in regard to Mr. Waskowski after that -- or during that physical exam?

A. Okay. The first thing I mention in my report -- and I'm using my report to refresh my memory since this was a year and a half ago -- was that there was great deal of what I call pain behavior.

Q. What is that?

A. Pain behavior is something that we all exhibit at some point. You know, if you're not feeling well and you tell your wife to get you a glass of orange juice, you could do it yourself, but it's easier for someone else to do it. That's pain behavior technically, but that doesn't interfere with your life or dictate how you really act all the time.

Pain behavior during an examination is -- and again some is perfectly normal -- is what I mentioned here, a great deal of pain behavior, grunting, panting, pulling away, things like that, a lot of verbalization, things like that.

The other thing I mention was as soon as I told him that go ahead and change into a gown, I was leaving the room as I mentioned, his wife jumped up out of her chair and came to his assistance. He's a big muscular guy, but came to his assistance to get changed.

And she did the same several times during the physical examination when he was trying to get onto the table, turning over, she jumped to his assistance several times.

So that's sort of a correlate to pain behavior.

Q. Why is that significant?

A. Well, I talk later about the disability mentality and when you -- I mentioned before have somebody else go get you the glass of orange juice. If that turns into day by day, month by month and year by year, and this was a year and a half later, that obviously has a huge effect on your level of functioning secondarily and just how you view yourself.

So the disability mentality is Mr. -- in this case Mr. Waskowski thinking that he's disabled and his wife sort of going along with that and helping him, you know, helping him move, turn over for example.

Q. Were there any physical findings after that observation that were significant to you?

A. Well, the first thing was having him move in six different directions of the low back.

Q. Could he do that?

A. Huh?
Q. Could he do that?
A. Well, he -- what I said he had about 5 percent of flexion, 5 percent of what I would expect to be normal for someone his age. He had about 5 percent of that.

He had zero extension. He could not tilt backward at all in any of the three directions. All of those he said caused severe pain or when he did move, he anticipated severe pain with any of those motions.

Significance is that there is nothing short of cancer eating away at your spine that allows essentially zero motion in any direction. In fact, actual conditions like a ruptured disk or even strains, some motions feel better. That's just -- that's the pattern I look for.

If this is a ruptured disk, certain patterns that sort of turn that light bulb on in my head, but this pattern, there's really nothing that causes that.

Q. Can you tell me what your understanding is of why some of those motions would actually make you feel better if you have a real ruptured disk?

Why would that occur?

A. Well, to take the example of a ruptured disk, there is typically swelling around the disk or even if there's not, if you're past that acute stage there's a physical thing there, there's a gumba there, there's disk material there.

If you tilt backwards -- and it's off to the back and the side if you look at the spine. So if you tilt backwards and to that direction you're going to literally crunch that area or the swelling around it which itself can then crunch the disk and cause pain.

But just the opposite is true. If you bend forward on the opposite side or even forward to the same side, but especially opposite that at a diagonal opposite, it takes the pressure off the area and it feels better, and the other motions are kind of in-between. So that's just an example of that.

The next thing I look for is I mentioned if there's a twist or a torque on the spine. Is the motion symmetric or is it asymmetric and he had very little flexion, very little bending forward, but whatever there was was normal. But you can also test that when they're lying down by looking at their different

anatomic areas, ankles and the hips, and there was no asymmetry, in other words, he was lined up okay.

Q. Let me ask you this too and I don't mean to interrupt you, but you mentioned that he was a big muscular guy?

A. Well, what I said was he was well muscled.

Q. And is that significant in your observation of the patient who claims to have had this kind of problem for 18 months?

A. I would say overall no. I mean, just because he's more heavily muscled does not mean he could not have a ruptured disk that is just as painful as somebody thinner or -- not necessarily.

Q. Very good. After the observation relative to his back, what if anything next did you find?

A. Next thing I talked about was what's called straight leg raise, so that's done in two ways.

First the person is lying flat out face up and without their help I take one leg at a time and slowly move it up, ask him though to tell me what he's feeling. And on the right side he had low back pain at about 5 or 10 degrees, meaning the leg was barely off the table a couple of inches.

On the left side there was severe low back pain at -- what I said zero to 5 degrees, so, you know, maybe an inch off the table. Now, that is done later in a different way. The person sitting over the side of the table and I'm testing their strength in their foot and something like that, but I'm also lifting their leg up to basically cause also a straight leg raise.

And in that part of the test he had no pain whatsoever and I got him to 80 degrees. Now, that's a big difference. Those two are not exactly equivalent lying out flat and then sitting, and if there were a 20 degree difference, if somebody said oh, yeah, that hurts at 40 degrees and I could do it to 60 sitting, that's fine.

Zero to 5 degrees versus 80 degrees is a huge difference, meaning that if there were an actual structural problem -- and what you're looking for is tension on the nerve causing the first, it should -- it would have to be there at the second.

So what this tells me it's a big discrepancy and there really is actually no

structural problem causing that first severe pain at zero to 5 degrees.

Q. What does straight leg raising supine or laying down, what does that test for?

A. It's meant to look primarily for tension on a nerve root so you have a pinched nerve. It will be irritated and if you stretch it by doing the straight leg raise, it causes more pain.

It also might bring out muscle tightness in a back or the hamstrings or anyplace else, but the same holds true. The two done in two different ways should be about the same.

Q. Is there any known musculoskeletal condition that would explain the difference between his presentation for straight leg raising while he was laying down and sitting on the side of the table, basically at a 90 degree angle?

A. There's no condition that would explain that, no.

Q. What, if anything else, did you notice relative to his presentation on the physical examination?

A. The next part of the musculoskeletal exam was palpation, pushing over not just the back muscles but where they attach and other areas.

He had tenderness pretty much everywhere on the left side more than the right,

but all through the muscles of his back for example. And I mentioned earlier that muscles will have a different feel to them if they've been tight for a few weeks, certainly a month or more. This had been a year and a half. Even though he was saying there was severe pain and there was also tenderness when I pushed over him, the muscles had completely normal feel to them, so it's another discrepancy.

Q. What did you examine next?

A. Then came the neurologic and all the parts I mentioned before, the reflexes, the strength, atrophy meaning measuring if there was any loss of the muscle mass, sensation, all that were completely normal in the legs.

Q. Did you find any evidence of diminished sensation in the L4-L5 nerve root distribution?

A. There was none.

Q. Could you tell the jury and me when we talk about nerve root distribution what that means?

A. Well, there's the major nerves that run down the arm or run down the leg. For the leg, for the low back, lumbar area the ones that supply the leg muscles mostly are L4 and L5, lumber 4 and 5 and S1, sacral 1.

And so each of those has a -- you know, from the anatomy textbook we're all different a little bit, but they pretty -- we're pretty consistent and each of those has a pattern of muscles that it supplies and a pattern of skin that supplies the sensation to.

And so I mentioned before touching or people use a pin, if they're numb or feel less in a certain distribution does that match or pretty closely match one of these major nerves.

Q. And there were no findings relative to L4-L5?

A. They were not, either sensation-wise or strength-wise or reflex-wise.

Q. Can you tell me what extensor hallucis longus is, please?

A. EHL, extensor hallucis longus, is the muscle that pulls up the big toe.

Q. Did you find any neurological compromise to that in your examination?

A. No, it was fully strong.

Q. What if any finding did you make relative to Mr. Waskowski's ability to raise and lower his foot? Did you check that?

A. Yeah, it's called ankle dorsiflexion, plantarflexion, all that was normal

strength-wise. He was very strong.

Q. Now, did that conclude your examination of his legs or was there more that you had done?

A. Other than watching him walk, and I said that his -- how he walked was mechanically normal meaning all the aspects of how you actually walk, putting it all together, but he was holding his -- or he was on his wife's arm for support, but his walking was otherwise normal.

And then I went on to the neck and arms.

Q. Before we move on to those, if you have -- what if any balance difficulties did Mr. Waskowski describe to you?

A. I don't believe he told me about balance, he didn't mention any balance issues at all.

Q. And he did not appear at your office with a cane or a walker or wheelchair or anything like that?

A. No, and his balance -- you know, when I have people move around, he didn't move much, but when I have them move around, if they have balance problems they usually grab a table or something and that didn't happen.

Q. When you moved on to the neck and arms, you conducted a physical examination of those areas

as well?

A. All the same components we mentioned before.

Q. Could you tell the jury what your findings were relative to the neck and arms?

A. Well, in the neck -- and I put people through, again, six different motions and there was in this case zero. He did not move his neck in any of the six directions at all.

And, again, I mention that maybe short of, again, cancer eating away at your spine or something like that, there's no musculoskeletal condition, there's no strain or ruptured disk or pinched nerve that causes that.

All of those he said he would have severe pain, but he didn't move at all. He was just anticipating severe pain. There's a maneuver called a Spurling where you position the head backwards and off to the side and put a little pressure down, see if it irritates a nerve root. Couldn't do that because he had to move the neck and he didn't move the neck at all.

Despite his severe pain, when I palpated, when I pushed firmly over his neck and shoulder muscles there was no tenderness whatsoever with pretty deep palpation, and like

the low back, those muscles had normal tone, normal texture, meaning they hadn't been tight at all recently.

Otherwise, I would have felt something there.

Q. What if any findings did you make in the arms?

A. I then did the neurologic, all the same things we talked about. Everything was normal strength and all that, reflexes except that he -- in the entire left arm he said it felt more numb to him than the right. The right felt normal, the whole right arm and the left arm, the entire left arm didn't feel the same.

I mentioned earlier that we look for numbness or decreased sensation in a certain nerve pattern, and that would mean something if it went along with other things. The entire arm being numb again is not from any -- there's no known condition not musculoskeletal -- I mean a stroke, something like that, but in what I'm looking for in Mr. Waskowski there's no known condition that would possibly cause that.

Q. While we're talking about the arm, could you tell the jury where the carpal tunnel is in the body?

A. The carpal tunnel is at the front of the wrist

and it goes from like the farther wrist line to about an inch or so where the palm sort of dives down. It's an area, a tunnel created by bones on the bottom and a ligament over the top.

Q. You noted in your report that there was no focal atrophy in the arms, is that correct?

A. Yes.

Q. Why is that significant?

A. I mentioned earlier that a pinched nerve if it's there long enough and bad enough can cause the muscle fibers to lose their nerve supply and they can shrink, that's atrophy.

Q. Now, at the time of your initial --

A. Can I add one more thing?

Q. I'm sorry, please.

A. There was just one more thing I did in the arm and that was on the left to test his rotator cuff.

Q. And could you tell the jury what the rotator cuff is?

A. Sure. It's a group of four muscles that comes from the shoulder blade up to the upper arm bone, the humerus, and just like it sounds it rotates the upper arm, very important for quarterbacks and pitchers, and we all do some motions that

involve the rotator cuff.

There are certain maneuvers that are specific for the rotator cuff and cause pain in a certain distribution and when I tested him he didn't have that pattern of pain.

Q. Did he or the person that was with him ever suggest to you or tell you that he had a history of post-traumatic stress disorder?

A. No. His wife was there, but also an interpreter was there, but I mentioned earlier in this report that I was able to get a full history, do a full exam even with an interpreter present, but no, no mention of PTSD.

Q. Now, your initial report you deferred your discussion. Why did you do that?

A. I had been sent a file of records a couple of inches I had mentioned before, but apparently it must have gotten to my office that day, day before, hadn't had a chance to look at them yet.

So I was going to defer final opinions until I did have a chance to look at those records, which I guess I did four days later.

Q. Now, what part does reviewing medical records play in your examination and evaluation of the patient?

A. I talked about earlier that it might help focus what you examine, but more importantly it just gives me insight into what others have found, what have they documented on examination, what the symptoms were, what the physical examination findings were.

I'm often asked in these kinds of evaluations, "Was the treatment medically necessary?" so that gives me some insight into that as well, all those kind of questions.

Q. Now, when you receive records such as were presented to you in this case, you don't investigate whether or not the findings are accurate or whether they're authored by the person or authentic or any of that I assume, is that correct?

A. That's correct in terms of being authentic. When you say "accurate", I'm not sure what you mean. I mean, I can look at the content of the notes medically, but in terms of whether Dr. X, Y or Z actually authored the notes, I don't get into that.

Q. Did you have a chance to review these records that were presented to you?

A. Yes, I did.

Q. And can you tell the jury what, if anything, you found significant in your record review?

A. Well, the early notes mentioned spine and left-sided pain. He did not lose consciousness. Most medical notes were from the person you mentioned before, Dr. Glowacki, and he first saw Mr. Waskowski three weeks later. Neck and low back pain, there was no mention of the shoulder, the arm or the leg anywhere.

However, Mr. Waskowski told him he couldn't dress himself, he couldn't take a shower himself, he couldn't do virtually anything for himself. There was tenderness in the spine and reduced motion. The left ankle reflex was said to be gone, said to be zero.

Dr. Glowacki mentioned rib and breastbone, sternum, fractures because of tenderness there and later in the records the imaging for that, for both those areas, was completely normal. There were no fractures there.

He then recommended MRI scans, physical therapy, what we call household assistance and attendant care, someone to basically take care of the house and Mr. Waskowski's personal care,

personal needs.

Q. I'm sorry if I --

A. All right.

Q. The issue of the bone scan and the x-rays, you've had a chance to look at those reports, am I correct?

A. The reports. I don't think I saw those actual images. I know I didn't see the bone scan. I don't think I saw the rib x-rays either.

Q. You saw the reports of those studies?

A. Yes.

Q. And will x-rays show fractures of the sternum and the ribs?

A. Yes.

Q. Is it true that 90 percent of the time x-rays will miss fractures of the ribs or the sternum?

A. 90 percent you say will miss them, will not show them?

Q. Yes.

A. No. Now, I will say that there are occasional rib fractures non-displaced so they're not out of place early on where the calcium -- what we call the callus, hasn't formed yet, but within a couple of days that will show up.

Q. How about with the bone scan, if there's a bone

scan that's done as you saw in this particular case, would that pick up fractured sternum and fractured ribs?

A. Yeah, right away. I was just looking for -- yeah, immediately for the bone scan. I was just looking for the date of the rib x-rays showing no fractures. That was on 1-4-10 meaning it was 9 plus 4, 13 days, about two weeks later, so there's no question that calcium would have clearly formed by then.

So while an x-ray immediately might not show a rib fracture, by 13 days there's no question it would if it were there.

Q. If you had suspected fractures of the ribs or the sternum and received those x-ray and bone scan reports would you have continued a diagnosis of fracture of the ribs and sternum?

A. Well, in my report, in the second report I made that point that Dr. Glowacki did continue listing that as -- both of those as diagnoses obviously incorrectly.

Q. What was the date on your second report?

A. July 11, 2011.

Q. Thank you. What if anything else did you find significant from your review of the records?

A. Well, I mention that he, Dr. Glowacki's, next three notes January, February, March one each 2010 were completely illegible.

That reason alone means they didn't rise to what we consider minimal standards of medical practice. You have to create legible and reproducible reports.

Q. Why is that?

A. Well, for the sake of medical documentation. If somebody else -- if Dr. Glowacki somehow weren't available and someone else were trying to treat Mr. Waskowski for something that was there you have to create legible notes. It's basic for the sake of the patient's medical care.

It seems pretty obvious. And I'm pretty good at deciphering physicians chicken-scrawls. I couldn't read a thing in any of those three notes.

Q. Very good. What if anything else did you find?

A. Well, the next note was in April of 2010. There was no examination. Dr. Glowacki did not think that PT would help, which I found interesting. I didn't comment it here, but that was after probably three months of therapy, but the therapy went on for another year plus after that.

He did think though that Mr. Waskowski might need an operation for his neck or his back. He later reports he listed MRI results. A note in June of 2010 said he was going to try to push him back to work. The next month though, July of 2010, there was zero motion in the neck or the low back, essentially what I found one year later.

His diagnoses continued to include fractured sternum, fractured ribs incorrectly. On December 10 of 2010 we were now six months -- oh, no, a year, I'm sorry, we were a year after the accident. There was a new finding of reduced sensation down the left arm in a certain nerve distribution a year later.

There were 12 more visits after that date, nine were completely unreadable. I could not decipher any physical examination.

Dr. Glowacki's note of -- in March of 2011 showed no change in his pain. He called the pain bitter. He mentioned -- that's a word he used. And then toward the end of his notes which was ending in June of 2011 because I was seeing him the next month he put in his note that Mr. Waskowski will have pain the rest of his

life, even if he has an operation from these issues.

Q. What if any evidence did you find as a result of your review of those records and your examination to indicate that that statement was true, that is that there would be pain there for the rest of his life?

A. We talked earlier about pain being a subjective symptom. There's no way to measure it, so if someone just tells me, "I have pain" and they tell me 20 years from now, "I still have pain and I've had pain since I saw you the first time 20 years ago," there's no way to say, "No, you don't have pain" or, "You didn't have pain" or, "Yeah, you did have pain."

All a physician can do, mostly by exam but also with some other tests, is to find a cause of that pain. Is there anything that explains this pain? Is there a reason for that pain to be there or is it what we call non-organic, no explainable reason for the pain?

So there's no organic reason in the big picture after having all the records and having examined Mr. Waskowski, there was no hint of an organic reason, an actual condition, what we call

impairment, to explain any pain at the moment or certainly the rest of his life which that statement by Dr. Glowacki, it doesn't make any medical sense either.

There are few conditions in my field, again cancer and whatnot, but very few conditions -- well, there's none that I can think of, zero, that cause pain the rest of your life.

That just isn't the way the body works.

Q. What other records did you review?

A. There was an orthopedic person who recommended spine injections, but later also said maybe he needs a neck or a back fusion.

There was one note from Dr. Zamorano, also not board certified, who recommended EMGs or I think she did EMG in all four limbs.

I talked about how much she billed for that and for other -- for like a lumbar corset and a cervical collar. There was an orthopedic evaluation in July of 2010 that concluded there was amplification of symptoms, meaning Mr. Waskowski was expressing a lot more symptoms than could be explained. And then there were a bunch of imaging studies, x-rays and MRI scans. The bone scan we talked about.

Q. Those imaging studies that you reviewed, did you ever have a chance to review the report from Dr. Quinn? I don't know if you did or not, but --

A. No, I did not.

Q. As a result of your review of all these records and your physical examination of Mr. Waskowski, were you able to come to a diagnosis -- or let me ask you that question first -- come to a diagnosis relative to his condition?

A. Well, there was no musculoskeletal or neurologic diagnosis because there was -- not only was there no impairment, no actual condition found, but the only findings if you will were inconsistent or non-organic. Things like the straight leg raise we talked about before 5 degrees versus 80 degrees, numbness in the entire left arm is not organic, that doesn't happen. Stroke, yeah, but not in this setting.

The huge amount of pain behavior, palpating the muscles that were very tender with minimal pressure even though they felt perfectly normal, so there was no musculoskeletal or neurologic diagnosis.

Q. What if any finding did you make regarding the

necessity of a repeat series of MRIs at Oakland MRI?

Did you make a conclusion relative to that?

A. I had concluded that there was reasonable -- a medical reason I should say to do one set of MRI scans, no reason to do any more than that, not as relates to the accident we're talking about.

Things don't change that quickly in the spine, they change over years as a natural process of aging and there was also nothing on examination when I examined Mr. Waskowski and apparently the other person too, but my exam hinting of anything related to the disk.

I mentioned earlier the patterns of the way the back moves and the disk. If there's a disk problem might feel better in certain -- none of that was present at all, not even a hint of that, so there would have been -- in fact one could argue whether the first set of MRI scans was even necessary because of that.

There are radiology guidelines that say there should be worrisome symptoms, progressive neurologic deficit, not just back pain, and those weren't present.

So one could argue about even the first set, but I would say okay, it's standard of practice to get the first set of MRI scans. There's no need for anything beyond that.

Q. This 18 months of physical therapy, did you have an opinion as to whether or not that was reasonable in these circumstances?

A. We touched on that before. If one says there might have been strains to begin with, muscle pulls, muscle strains in the neck and low back. Those weren't documented by Dr. Glowacki's input, but if they were there, a month of PT is what's considered justified.

We talked before, the ODG says 10 visits, that's about three weeks if it's three times a week. I would say a month.

If the person is doing a whole lot better when I see him back I might give him another couple, three weeks, some people say two months. But at that point, you know, the way I word it is it makes not only no medical sense, but it makes no just general common sense to keep up with a year and a half of treatment that Mr. Waskowski basically says is worthless. He was no better at any time, not even temporarily.

In fact, he was slowly worsening over time. So to provide that such therapy, there's no possible justification for it, no explanation for it.

Q. Is it normal for a person of -- I believe Mr. Waskowski was 46 years old when he came to see you or close to 46?

A. He was 48 when I saw him, but it had been a year and a half, so maybe he was 46 at the time of the accident.

Q. Do you expect degenerative changes in the spine of a person of that age?

A. Yeah, those are there if you look for them by -- in many people by 35, a lot of people by 40, all of us by 45 or 50. Certainly 100 of us to some extent.

Choosing your grandparents or great-grandparents will tell you if there's a little bit or a lot. So make sure you choose wisely, but it's going to be there.

Q. So if the suggestion was made by Dr. Glowacki that there would be no reason to believe that there was degenerative changes in the spine of Mr. Waskowski, would you agree or disagree with that proposition?

A. You mean because of his age at 46?
Q. Because of his age at 46?
A. Well, 100 percent of people have changes in their spine, so that's fully incorrect.
Q. I'm trying to phrase this question eloquently, but I don't know how to do it. If you don't find that there's any organic reason to explain pain and there's no impairment, is there any way to say that he was injured in this accident from your examination?
A. Well, remember we have to separate symptoms from an actual condition.
Q. Yes, sir.
A. So when someone tells me they hurt, they hurt. My job, whether I'm treating them or whether I'm seeing them for evaluation only, is to look for the injury, look for the actual condition that is causing the ongoing pain.

A lot of people have -- whether it's a small or a large accident and to me the amount of damage doesn't make much difference, I've seen it all different ways. You have an impact to the spine, you can get -- the muscles are jarred, what we call the soft tissues, ligaments and connective tissues, and people hurt for a few

days to a few weeks or something like that.

Beyond that, you get contusions, bruises basically of the muscles of the bone and that can hurt for a few weeks to a month or so and then you get into other things like ruptured disks or pinched nerves, or full-blown strains and those can hurt anywhere from a few weeks to a few months, several months if it's a ruptured disk, and that's where you need actual treatment.

There is nothing in this file from Dr. Glowacki or the imaging studies or from when I examined him a year and a half later to show that there was any actual condition that occurred on December 23 of '09.

Did he get bounced around? He certainly could have gotten bounced around, so the initial aches and pains could certainly -- were probably undoubtedly there, but in terms of ongoing for a year and a half, you know -- the other point too is that a year and a half of therapy, we talked about it doesn't make sense to keep going with what is essentially worthless therapy, but actual medical conditions get better, not only with time, but also with treatment.

So there's virtually nothing anybody can think of that lasts for a year and a half without getting better. Now, add in if there was something real and you're getting therapy aimed at it, you know, he was getting worse over time.

There's really no known condition that fits that pattern.

Q. Could you tell me if you were going to determine in a particular patient that they needed attendant care, what types of things would you evaluate or look for if you were going to make that decision for one of your patients?

A. The most common reason for attendant care in my field but that I don't deal with is head injury, an actual brain concussion, long-lasting concussion, brain injury, TBI.

From the musculoskeletal standpoint there is virtually nothing, virtually nothing that requires attendant care. Now, that's not household assistance or replacement services. You're asking only about attendant care.

Q. Yes, sir.

A. So that's personal, you know, bathing and dressing and brushing one's teeth and washing one's hair and showering, that sort of thing.

There is almost nothing you can think of. Now, if one has just had an operation, you just had a back fusion or neck fusion or a shoulder operated on for the rotator cuff, sure, in the postoperative area a few weeks or something before you get back on your feet.

But from ongoing conditions, I do request attendant care in other settings, but for a simple straightforward musculoskeletal condition, even if there were a ruptured disk, even if there were pinched nerves, certainly strains, those do not require attendant care medically.

Q. There are devices also to assist persons who are physically disabled, am I correct?

A. You mean like reachers and things?

Q. Reachers and long-handled sponges and that sort of thing.

A. Right.

Q. Did Mr. Waskowski ever mention to you or the person who was there with him or his interpreter tell you that anyone had ever prescribed any type of assistive devices for him when you saw Mr. Waskowski?

A. He didn't offer that, but to be fair I didn't ask

him.

Q. Would you have prescribed any for him?

A. No, there is no medical need for that.

Q. Last thing I want to ask you is, what is malingering?

A. Malingering has a specific diagnosis -- or a specific definition. In fact, that's the only possible diagnosis I raised here. That is a conscious effort on the part of somebody to appear disabled or when they act disabled when there is no medical reason for that disability.

Q. Was that part of your diagnosis for Mr. Waskowski?

A. In the end that was really the only diagnosis.

DEPOSITION EXHIBIT 2
reports dated 7-7-11 and 7-11-11
WAS MARKED BY THE REPORTER
FOR IDENTIFICATION.

Q. Sir, I'm going to show you what I've marked as Exhibit 2. I believe I've stapled together both of your reports. If you could take a look and make sure those are accurate copies of your reports?

A. Yes, they are.

MR. HEWSON: I will move the admission

of my two exhibits and I have nothing further of the doctor at this time. Thank you, sir.

THE WITNESS: Okay.

EXAMINATION

BY MR. TEMROWSKI:

Q. Doctor, before the deposition began you allowed me to look at your file which I'm now going to hand back to you --

A. Okay.

Q. -- and I have taken some documents out of that file that I'm going to have marked as exhibits and then ask you about.

But could you just hold that file up and let the jury see your file on Mr. Waskowski and who provided that file to you?

A. I assume it was the same group that sent him to me, MES. That's who my letters are addressed to.

MR. TEMROWSKI: So we don't have to waste time, why don't we go off the record and I'll have the court reporter mark the documents that I took out and then we'll go back on and I'll ask you the questions.

THE WITNESS: Okay.

VIDEOGRAPHER: Going off the record at 1:47 PM.

(A recess was taken).

VIDEOGRAPHER: We're back on the record at 1:51 PM.

BY MR. TEMROWSKI:

Q. Doctor, since Mr. Hewson began by questioning you about your credentials, your qualifications, I guess I'll begin there also.

You indicated that you're a clinical professor at Wayne State Medical School, correct?

A. Yes.

Q. Is that what you do full time?

A. No, not at all.

Q. You have no hospital affiliations?

A. Correct.

Q. Do you actually treat individuals who have been injured in automobile accidents?

A. Yes.

Q. And your specialty is physical medicine and rehabilitation, correct?

A. Yes.

Q. You are not an orthopedic surgeon?

A. Right.

Q. And do you perform surgery on individuals at all?

A. No.

Q. Have you ever performed a neck or a back surgery?

A. No.
Q. Now, we've established that you've authored two reports?
A. Correct.
Q. And the first report was July 7, 2011 that you sent to MES?
A. Right.
Q. And that was prepared and sent to you -- sent by you to them on the day that you examined Mr. Waskowski?
A. Well, it was prepared the same day. We will -- I'll have it typed out, but the next day I'm in the office, whatever that turned out to be, is when I -- I review them at home online, edit it and then the next business day, next time I'm in the office, it gets mailed out that day.
Q. Do you have that report in front of you?
A. Yes, I do.
Q. Take a look on the first page towards the bottom, you indicate that before this automobile collision occurred Mr. Waskowski didn't have these type of problems, correct?
A. Correct.
Q. And that before the automobile collision of December 23, 2009 he wasn't treating with any

doctors, correct?
A. Right.
Q. Didn't undergo or need any medical testing or treatment?
A. Right.
Q. Was able to work?
A. Yes.
Q. And was under no limitations at all?
A. Correct.
Q. And in fact he was very healthy in general and took no medications at all before the automobile collision, correct?
A. Right.
Q. And Mr. Waskowski, if you now turn to Page 2, you indicated that he was employed as a road truck driver?
A. Right, over the road.
Q. And he'd drive up to a thousand miles a day?
A. Right.
Q. And that Mr. Waskowski has not worked since the automobile collision of 12-23-09?
A. Correct.
Q. You then performed your exam on Mr. Waskowski?
A. Right.
Q. But -- and authored this report?

A. Right.
Q. But as you state two times in this report, you're not going to give an opinion on Mr. Waskowski's medical condition until you review the records?
A. Right.
Q. And as I understand it after this examination you were provided records which you have in front of you?
A. They were actually provided before. As I mentioned, I didn't have a chance to look at them, but yeah, they were provided concurrent.
Q. And that's what's in your file in front of you, correct?
A. Yes.
Q. And, as you've testified, you've reviewed all those records?
A. That's right.
Q. Because it was important to do so?
A. Right.
Q. Now, your second report, if you take a look at that because it's the report I'm going to go through now with you is dated July 11, 2011.
And again this report is sent to MES, correct?
A. Right.

Q. In the second paragraph entitled "Record Review", you indicate -- and I'm going to quote it and read it, you wrote,

"Photographs presumably from this event show moderate damage to the front driver's side and mild damage to the rear driver's side of a small sedan."

Correct?

A. Right.

DEPOSITION EXHIBIT 3
copy of two photographs
WAS MARKED BY THE REPORTER
FOR IDENTIFICATION.

Q. And in your file, and I'm going to now hand you what I've had marked as Deposition Exhibit 3, are those the photos that you reviewed and referred to?

A. Well, if you pulled them from here, then yes.

Q. Yes.

A. I mean, a year and a half later I don't have recollection, but if they were pulled from there, then yes, these are the ones I saw.

Q. And in your opinion is that moderate damage to a motor vehicle?

MR. HEWSON: Objection, foundation.

Doctor, to the extent you have an answer, go ahead.

MR. TEMROWSKI: Well, that's the doctor's own words.

MR. HEWSON: I understand, but I'm saying foundation. I don't think it's relevant; go ahead.

A. I said there was moderate to the front end, front driver's side, and yeah, I would call that moderate. I've certainly seen a whole lot more and a lot less and quite mild on the back.

BY MR. TEMROWSKI:

Q. Then if you look on Page 2 of your report you indicate that you reviewed records from a Dr. Donahue, correct?

A. Yes.

Q. And you indicated in your report that Dr. Donahue's name does not appear on an ABMS website?

A. Correct.

Q. What does that mean?

A. I mentioned earlier that there was 24 major specialties. They all sit under the umbrella organization called the ABMS, the American Board of Medical Specialties.

They have a website that you can put someone's name in and see if they're board certified in anything. Dr. Donahue -- at the time -- this is only a year and a half ago, but at the time I didn't know there was a way to do the same thing, to look up for a D.O. He's an osteopath, so I mention there he's not on the ABMS website, but a lot of osteopaths are not because they get certified through the osteopathic boards. I said he though is a D.O. I have since, probably soon after that because it's been a while, I since have found there is a way to look for the same thing.

So if you were to tell me he's board certified in orthopedic surgery, I consider those equivalent, you know, the D.O. boards and the ABMS boards.

Q. Do you know Dr. Donahue?

A. No.

Q. Do you know what hospitals he's on staff at?

A. No.

Q. But you did review two reports that he authored, correct?

A. Yes.

Q. And those reports are dated August 19, 2010 and

December 14, 2010, correct?

A. Right.

DEPOSITION EXHIBIT 4
reports dated 8-19-10 and 12-14-10
WAS MARKED BY THE REPORTER
FOR IDENTIFICATION.

Q. And they're in your file and I've had those pulled out and marked as Exhibit 4. I'm going to hand them to you.

A. Okay.

Q. And I'd like to start with the August 19, 2010 report.

MR. HEWSON: I will object to both of these in that they are hearsay and if they're being admitted for the truth of the matter contained therein, there is no foundation.

Subject to that of course we'll take your answers.

BY MR. TEMROWSKI:

Q. Dr. Donahue in his report indicates that Mr. Waskowski was seen for a second opinion, correct, very top of the report, first sentence the 8-19-2010 --

A. Oh, I'm sorry I had the wrong one in my hand. Yes, second opinion, right.

Q. And it talks about the motor vehicle accident of December 23, 2009, correct?
A. Yes.
Q. And it indicates that Mr. Waskowski was complaining to [sic] pain to various parts of his body, correct?
A. Right.
Q. Including his shoulder and his back?
A. Ah, let's see. Cervical spine, lumbar spine, left shoulder and left leg.
Q. And Dr. Donahue in his report that you have, he performed a physical examination upon Mr. Waskowski, didn't he?
A. Yes.

MR. HEWSON: Objection, foundation; go ahead.

BY MR. TEMROWSKI:
Q. And that physical examination is -- the findings were different than what you found, aren't they --
A. Yes.
Q. -- when you examined Mr. Waskowski?
A. They are.
Q. And in fact there are several -- what would you call them -- abnormalities that he found when he

examined Mr. Waskowski?
A. Abnormal physical findings.
Q. And there's -- at the bottom of the page it discusses the MRI, correct?
A. Yes.
Q. And would you just read from that report what the MRI indicates?
A. He writes that the MRI of the cervical spine demonstrates basically ruptured disc, herniated nucleus pulposus greatest at C4-5 and C5-6.

Further he says there is another ruptured disc in the low back between L5 and S1.
Q. And he arrives at an impression, doesn't he?
A. Yes.
Q. And would you read what that states?

MR. HEWSON: Objection, same thing. Go ahead, doctor.

A. He has -- the impression was involved in the accident, suffering to the cervical and lumbar spine, but then more specifically the same three disks he just mentioned from the MRI scan.
BY MR. TEMROWSKI:
Q. And then Dr. Donahue arrived at a plan for treatment, correct?
A. Yes.

Q. And in fact his plan for treatment was to have Mr. Waskowski follow up with Dr. Glowacki for injections of the said areas with epidural steroid, is that true?
A. That's what he wrote.
Q. Then, doctor, if you could look at the other report that Dr. Donahue authored, the report dated December 14, 2010, in the very last paragraph Dr. Donahue discusses --
A. Sorry, of the second page?
Q. Of the second page?
A. Okay, yep.
Q. And Dr. Donahue discusses a possible surgical intervention, isn't that true?
A. He does.
Q. And would you please read to the jury what Dr. Donahue wrote regarding a possible surgical intervention?

MR. HEWSON: Objection, hearsay. Go ahead.

A. He once again talked about these injections that we mentioned from the first visit, but then he said if he does not have significant improvement from those injections we may discuss some surgical intervention which would include

possible disk removal versus fusion in the low back and a fusion in the neck.

I mean, technically other words, but that's what he meant.

BY MR. TEMROWSKI:

Q. And again, doctor, Dr. Donahue is an orthopedic surgeon and you are not, correct?

MR. HEWSON: Objection, foundation. Go ahead.

A. Well, I'll assume he's board certified. If you know that or not, but I assume he's board certified, so I'll say yes, he's an orthopedic surgeon and I am not.

BY MR. TEMROWSKI:

Q. Okay. Now, I've already pulled from your records Dr. Zamorano's report that you and Mr Hewson talked about here.

A. Briefly.

MR. HEWSON: Same objection regarding hearsay and foundation. Go ahead.

BY MR. TEMROWSKI:

Q. And, again, just so I'm clear, doctor, you did review these reports, didn't you?

A. Yes.

Q. And they're in your file?

A. Yes.
Q. And you indicated that -- I'm quoting you and if it's inaccurate, please let me know -- but I believe you testified that these reports and records give you insight as to what others have found?
A. Right.

DEPOSITION EXHIBIT 5
report dated 3-18-11
WAS MARKED BY THE REPORTER
FOR IDENTIFICATION.

Q. So now we have Dr. Zamorano's report which I've had marked and handing you as Exhibit 5. And if you could please look on Page 3 of her report regarding Mr. Waskowski --
A. Okay.
Q. -- there is a heading entitled "Medical Diagnosis", do you see that?
A. Diagnostics, yeah, testing.
Q. And would you please read to the jury what that states?
A. The whole paragraph?
Q. That paragraph.
A. MRI of the left shoulder on September 28, 2010 reports a degree of rotator cuff strain and small

tears in the cartilage of the shoulder. There are some arthritis claims as well.

MRI of the low back, the lumbar spine, shows disk herniations at two levels, L4-5, L5-S1 and then MRI of the neck shows multiple disk herniations, she mentions two levels, C4 through C6 and then that was really it for significant findings.

Q. Okay, and then right below that there is a section entitled "Assessment"?

A. Yes.

Q. And would you please read what Dr. Zamorano wrote there regarding Mr. Waskowski?

A. She said he was involved in an MV -- a car accident which resulted in neck pain from disk herniations, low back pain from two disk herniations and left shoulder pain from these cartilage tears.

She also mentioned dizziness which I didn't really deal with.

Q. And then right below that on her report is a section entitled "Medical Decision Making", correct?

A. Yes.

Q. And isn't it true, doctor, that in that section

of her report Dr. Zamorano wanted Mr. Waskowski to undergo additional MRI testing?

MR. HEWSON: Objection, foundation. Go ahead.

A. For the brain, for the dizziness, but yeah.

BY MR. TEMROWSKI:

Q. And she also recommended that he be fitted for a neck brace and a back brace?

A. Correct.

Q. Now, going back to your second report on Page 2, you evidently have in your file and you reviewed other medical reports that were performed by other physicians who did independent medical examinations on Mr. Waskowski, correct?

A. I think there was just one. That second from last paragraph says orthopedic IME. I think that was the only other one, only one.

Q. Okay, well, we'll get --

A. Is there another?

DEPOSITION EXHIBIT 6
reports dated 7-23-10 and 9-3-10
WAS MARKED BY THE REPORTER
FOR IDENTIFICATION.

Q. Well, yes, and we'll get to that in one second. Again, I pulled these documents from your file.

They've been marked as Exhibit 6.

I'm going to hand those to you and those are reports from a Dr. Higginbotham, correct?

A. Yeah, that's right.

Q. And they were in your file?

A. Yes.

Q. And you looked at them?

A. Yes.

Q. And Dr. Higginbotham is an orthopedic surgeon, correct?

A. Yes.

Q. And he performed an independent medical examination on Mr. Waskowski, correct?

A. Yes.

Q. And Dr. Higginbotham authored two different reports, one is dated July 23, 2010 and the other September 3, 2010, correct?

A. Yes.

Q. If you would look at the July 23, 2010 report on Page 4 at the bottom there's a heading called "Diagnostic Impression", correct?

A. Yes.

Q. And then if you flip the page to Page 5 the second paragraph, would you read to the jury the

first sentence of the second paragraph what Dr. Higginbotham wrote after he examined Mr. Waskowski?

~~MR. HEWSON: Objection, hearsay. Go ahead.~~

A. It would be appropriate for him, the patient, to have a course of an epidural steroid injection to see if this would be beneficial for him.

BY MR. TEMROWSKI:

Q. And then if you would please look at --

A. Now, you know, let me just be fair here and you asked me to read the first sentence, but there's a pretty important point in the next sentence which he says this could be useful as a diagnostic test as well as a therapeutic one, meaning diagnostic if his pain were taken care of that might be a useful procedure.

So he wasn't saying that he had a definite reason for the epidural, possibly to see if there was an actual condition.

Q. Okay, and then if you would look at Dr. Higginbotham's second report that he wrote, and -- you've got that in front of you, correct?

A. Yes.

Q. And the very first sentence in Dr. Higginbotham's

independent IME report of September 3, 2010 states, and I'm quoting, "I had an opportunity to review actual images of the MRI of the cervical spine on Jaroslaw Waskowski", correct?

A. Yes.

Q. And Dr. Higginbotham is an orthopedic surgeon, correct?

A. He is.

Q. And in the second paragraph down from that would you please read to the jury what Dr. Higginbotham wrote in his report after he personally reviewed the actual MRIs?

MR. HEWSON: Objection, foundation, hearsay. Go ahead.

A. He said that he shows multiple level disk herniation at three levels in the neck and two levels in the low back.

Was that all from that report you were going to ask me about?

BY MR. TEMROWSKI:

Q. That's all I was going to ask you.

A. Because, again, there's context here and there's a lot more in that report that plays into this.

MR. HEWSON: I'll ask you about it.

THE WITNESS: Oh, okay.

BY MR. TEMROWSKI:

Q. But that is what he wrote?

A. That's what he wrote, that's part of what he wrote.

DEPOSITION EXHIBIT 7
addendum to report dated 2-18-11
and addendum to report dated 11-16-10
WAS MARKED BY THE REPORTER
FOR IDENTIFICATION.

Q. Now, when you were kind enough to let me look at your file, on the very top of your file that I pulled out I've had marked as Exhibit 7 is actually two reports from another doctor who performed an independent medical examination on Mr. Waskowski and that is a Dr. Zachary Endress who again is an orthopedic surgeon.

MR. HEWSON: Objection, foundation. Go ahead.

A. You know what, I did -- the last sentence of the paragraph in my report says another orthopedic evaluation agreed with ESI. This may shorten that line of -- agreed with ESI.

BY MR. TEMROWSKI:

Q. Well, doctor, again I've had Dr. Endress' two reports that were in your file marked as Exhibit

7, I'm going to hand those to you.

Do you have any reason to doubt that Dr. Endress is an orthopedic surgeon?

A. No.

Q. Please take a look at Dr. Endress' independent IME report dated October 25, 2010.

A. The only two you handed me -- the actual evaluation was done on November 16 of 2010 -- oh, no, that was an addendum, so I guess I'm missing one.

Q. No, no, that's the one I want to ask you about.

A. Okay.

Q. The addendum and that is what date?

A. November 16, 2010.

Q. Okay, could I just see that a minute? Okay, this is the one I wanted to ask you about.

For starters, could you please tell the ladies and gentlemen of the jury who did Dr. Endress write that report to?

A. State Farm Insurance.

Q. And is there a particular adjuster?

A. Terri Page.

Q. And in this report that Dr. Endress wrote on November 16, 2010 he is responding to several questions that the adjuster Terri Page asked

Dr. Endress, correct? Take a look at it.

A. I assume so, yes.

Q. Would you please, doctor, read for the jury the first question that was asked by the claims adjuster and what Dr. Endress' answer was to the first question?

MR. HEWSON: Objection, foundation, hearsay. Go ahead.

A. They basically asked what's the diagnosis. His answer was herniated cervical and lumbar disks.

BY MR. TEMROWSKI:

Q. And please read the second question that was asked and what his answer was?

MR. HEWSON: Same objection.

A. It says what are your diagnoses of Mr. Waskowski. He gave the same answer, disk herniation both the neck and low back and then he goes on to say he agrees with trying these epidurals.

BY MR. TEMROWSKI:

Q. And what is the third question that was asked him and what was his answer?

A. Has he reached pre-injury status, answer was no.

Q. And what was the fifth question that was asked and what was his answer?

A. Is he yet able to return to pre-accident activity

levels including at work, and he said no, not yet.

Q. And last but not least would you read to the jury what was the sixth question that was asked and what was his answer?

A. They asked about replacement services, household assistance, chores. He said I think he does need help with laundry, meal preparation and landscaping, outdoor activities.

Q. And then you have another letter there?

A. Oh, yeah.

Q. Correct?

A. Yes.

Q. And, again, that is a letter dated February 18, 2011?

A. Right.

Q. And, again, that report is signed by Dr. Endress who did the IME on Mr. Waskowski?

~~MR. HEWSON: Objection same, same objection, hearsay. Go ahead.~~

A. It's not signed by him, but authorized signature by him, yes. There's some initials below who signed it, but that's all right. He generated the report.

BY MR. TEMROWSKI:

Q. And you don't doubt that, do you?
A. Correct.
Q. And, again, would you tell the ladies and gentlemen of the jury who was this report sent to?
A. Same, State Farm and Terri Page.
Q. And Dr. Endress writes to Ms. Page -- and correct me if I'm not reading it right -- "I have reviewed the additional records that you provided to me regarding Mr. Waskowski," correct?
A. Yes.
Q. "As I mentioned in my original report, I think that he does have loss of some services including laundry, meal preparation and yard work as well as landscaping activities"?
A. That's what he wrote.
Q. And that was on February 18, 2011?
A. Yes.
Q. Just a few follow-up questions and I'm almost done.
A. Sure.
Q. But I believe that you testified to Mr. Hewson and indicated that in your experience that physical therapy should only be given to an individual for eight or nine visits for about

three weeks, is that true?
A. That was for a strain.
Q. For a strain?
A. Ten, up to 10 visits, 10 or 12.
Q. What about through for a herniated disk?
A. Herniated disk without radiculopathy, without a pinched nerve, would be possibly six or even eight weeks.
Q. At most?
A. Typically at most if all goes well.
Q. And you indicated when Mr. Hewson asked you a question about an injury -- I guess he was asking about what Dr. Glowacki said about Mr. Waskowski that Dr. Glowacki believed that because of his injuries Mr. Waskowski would have pain for the rest of his life?
A. Right.
Q. And you don't agree with that?
A. Correct.
Q. Well, have you ever, doctor, in your experience of dealing with people who have neck and back injuries and specifically herniated disks, have you ever heard of someone having problems for the rest of their life because of a herniated disk?
A. What I actually said before to Mr. Hewson was

there's no known musculoskeletal condition, again not cancer or something, that explains pain for the rest of your life.

I mention that if someone told me 20 years from now I've had pain since I met you 20 years ago, there's no way to say yes or no to that because it can't be measured.

There's no way to refute or confirm that somebody actually has pain. The question is what is the cause of that pain, is there something explainable causing that pain in the organic world as opposed to something non-organic.

Q. Now, if I understand your testimony correctly when you were asked about your diagnosis for Mr. Waskowski you indicated that there was no condition found and that he was a malingerer?

A. When I examined him --

Q. Is that your diagnosis of him?

A. That is my -- and remains my diagnosis even with the other records I just looked at, yes.

Q. And is it your opinion that if a person did have herniated disks in their neck and back in your opinion that that individual would not need attendant care?

A. From herniated disks they would not, no, absolutely not. If that person went through a fusion I mentioned earlier that post-op they would need temporary attendant care, but not for the condition itself.

Q. So absent a surgery, no fusion, they don't need attendant care at all?

A. For a herniated disk?

Q. For a herniated disk.

A. No. You're asking for attendant care, not household assistance?

Q. No, I'm asking only about attendant care.

A. Correct, that's my opinion.

Q. Now, doctor, what injuries do you believe Mr. Waskowski suffered in the automobile collision of December 23, 2009?

MR. HEWSON: Objection, foundation. Go ahead, please.

A. Well, what I can say is I examined him a year and a half later, so when I was asked about looking at records, that's when I mentioned I see what other people were looking at and what their conclusions they came to.

I look for things that would objectively document, let's say, exacerbation of

pre-existing cervical and lumbar spine degeneration as a possibility, or herniated disk. These were degenerative disks, but they can be exacerbated.

There was nothing in any of Dr. Glowacki's notes, many of which were illegible, and nothing in the independent evaluations you mentioned from the two different physicians that to me documents the pattern of findings that I expect to find with those conditions.

So that's why my conclusion was there's nothing to suggest an impairment, nothing to suggest an actual condition.

BY MR. TEMROWSKI:

Q. And now, doctor, you're aware that Mr. Waskowski underwent MRI testing not once but two times?

A. Right.

Q. First time at Macomb MRI and then quite a while later at Oakland MRI, correct?

A. Right.

Q. And you've got those reports in your file?

A. Right. I also looked at some of those images, not all of them.

Q. And would you agree with me, doctor, that the

written reports from both of the facilities that performed the MRI testing on Mr. Waskowski's neck and back clearly wrote down by the radiologists that read them herniated disks?

MR. HEWSON: I'm going to object to the foundation, it's a compound question. To the extent you can, please answer.

A. The reports said herniated disks, yes, both reports both times -- I mean both places.

BY MR. TEMROWSKI:

Q. We agree that that's what they say?

A. That's what they say.

Q. And in the case of Mr. Waskowski you commented to Mr. Hewson again about Dr. Glowacki's diagnosis of fractures, but as I understand it you yourself never actually saw the actual bone scan, only the written report?

A. Right.

Q. And you never actually reviewed with your own eyes the x-rays, you only looked at the report?

A. Right.

Q. As opposed to these other doctors that we talked about who are treating doctors of Mr. Waskowski, you performed a one-time exam, correct?

A. Correct.

Q. And that exam was done on July 7, 2011?
A. Right.
Q. And is it true that all of the opinions that you're giving this jury today are based upon that one-time exam and your review of the records?
A. Right, along with my experience and general knowledge, but yes, for Mr. Waskowski only those.
Q. You don't agree with Dr. Glowacki?
A. In general, correct.
Q. You don't agree with Dr. Zamorano?
MR. HEWSON: I'm going to object. There's no foundation for that, but go ahead.
MR. TEMROWSKI: Well, let me rephrase it then.
BY MR. TEMROWSKI:
Q. Do you agree with Dr. Zamorano's assessment of Mr. Waskowski?
MR. HEWSON: Object, there's no foundation that she made such an assessment, but subject to that you can answer.
A. I think the only comment I made about her input was the EMG testing.
BY MR. TEMROWSKI:
Q. Do you agree with Dr. Donahue's assessment of Mr. Waskowski?

A. If he is saying that his exam found symptomatic clinically relevant disk herniations, I disagree with that.

Q. Do you believe that Mr. Waskowski ever needed household assistance?

MR. HEWSON: Objection, foundation, relevance. Go ahead.

A. Well, when I examined him certainly not. Based on the records I reviewed no, I do not think so.

BY MR. TEMROWSKI:

Q. So you don't agree with Dr. Endress who performed an independent medical examination on him?

A. I do not.

Q. And I take it you don't agree or don't believe that Mr. Waskowski needed or ever needed attendant care?

A. Not attendant care, certainly not.

Q. Is your opinions that you're giving to this jury today limited to the date of your examination of Mr. Waskowski?

In other words, you didn't see him before July 11, 2011?

A. July 7, but correct.

Q. And you don't know what his condition was like then, correct?

A. Well, what I can give opinions about is from direct observation of him that one date, but of course the file is where I got the rest of my information.

Q. Now, I'd like to finish up by just asking you we've established that you performed a one-time independent exam and that was done at whose request?

A. MES, secondarily State Farm apparently.

Q. And would you please tell the ladies and gentlemen of the jury who exactly is this MES?

A. I consider them kind of an outfit that brokers these exams. They will have physicians go into their own offices to perform these exams and I believe in the case of MES it's all defense side.

I did that for a very short time when I went into my own private practice in '99 for about a year, but otherwise they would send people to me, again sort of brokering them through -- I don't know if it's State Farm -- in this case State Farm. I'm not sure who else they might deal with.

Q. And you've been working with MES for how long?

A. I've believe since '99 at least to some extent.

Q. And what exactly is your legal relationship to

MES?

A. None.

Q. Are you an independent contractor?

A. Yes, there's none of these companies that I go into their office or have any agreement with other than I'm happy to take patients from them and -- or, you know, referrals from them and I assume they -- well, I think they're the ones, for example, it doesn't come straight from State Farm.

I think MES or people like them will copy the records and do things like that.

Q. And in the case of Mr. Waskowski did you generate a fee that was charged for your exam of him and your review of the records?

A. Sure.

Q. And would you please tell us what was your fee?

A. The fee last year was $740 for the exam which includes up to 15 minutes of record review and the exam and the report.

And then the record review I can probably tell you, because I charge that at the same rate, hourly rate, but in 15-minute increments, and this was an hour and three-quarters, so an hour and three-quarters,

one and three-quarters times $740, what is that, another $1,300 and something maybe on top of that, so a little over $2,000 total.

Q. And who paid you that fee?

A. It usually would come from MES itself.

Q. And in addition to that fee did MES charge a fee?

MR. HEWSON: Objection, foundation. Go ahead.

A. I have no idea, but I assume they're in business to also -- they can't stay in business without charging a fee, so I don't know what they might charge on top of that.

It wouldn't make good business sense for them to just pay me whatever State Farm pays them, so I assume they get a fee for what they do.

BY MR. TEMROWSKI:

Q. And what about for today's deposition, what is your fee to that?

A. A new year, so I went up $20, so it's $760 per hour now.

Q. $760 per hour?

A. Right, for the deposition.

Q. And is MES paying that fee?

A. I don't know, I don't think so, I'm not sure.

I'm not sure where the request for the deposition came from, if Mr. Hewson -- I just don't know. Ultimately I would assume it gets paid by the insurance company.

Q. State Farm?

A. By State Farm.

Q. And this examination that you actually performed -- I'm not talking about the record review -- the exam of Mr. Waskowski, how long did that last?

A. Face to face, about 30 minutes.

Q. And, doctor, what percent of your -- what shall we call it -- your livelihood is devoted to doing these types of examinations?

MR. HEWSON: I'm going to object to the foundation unless you're asking just about State Farm. Any other inquiries are irrelevant, but subject to that you can answer.

A. I mentioned earlier that about 60 percent of my practice is treatment and the other remainder are evaluations, evaluation only.

BY MR. TEMROWSKI:

Q. And have you ever done these types of evaluations in the past for State Farm?

A. Oh, yeah.

Q. How many?

A. I don't keep track of numbers by provider or by insurance company. My sense is that State Farm, of all the people who send folks to me is the single biggest sender of these evaluations, not majority but the plurality.

Again, I don't have a way of actually counting them.

Q. And on this last question, I want to make it perfectly clear that I'm not inquiring about your income from your private practice, but what was your income last year for performing these one-time examinations.

MR. HEWSON: Objection, foundation and if it doesn't relate to State Farm it's irrelevant. Subject to that you can answer.

A. Well, I've been asked that many times and the problem is I can't really tell and I don't have a good way of keeping track other than going through my records one person by one person which I'm not going to do.

The reason is because when I get people from State Farm for these evaluations or from other insurance companies I also get people from them for treatment, and so when I get a statement at the end of the year, you know, the 1099 at the

end of the year, it includes all of those.

And so -- and they don't separate them out, so there's really no good way for me to separate it, there's no possible way for me to separate that out, so I really don't know.

BY MR. TEMROWSKI:

Q. How many of these exams would you estimate that you performed this year?

A. Oh, boy. Again, I don't keep -- I know I'm usually asked what percent of my practice is this. That's why I know ballpark in the 40 percent, 35, 40 percent. Actual number-wise I really haven't been asked -- or not asked that very often so I don't have that number.

I know it's about 40 percent.

Q. Well, if you had to give it your best shot, how many individuals would you say in the year 2012 you examined like you did Mr. Waskowski?

A. Again, I don't have a good way to even estimate that. Ballpark, a few hundred, I don't know, yeah.

MR. TEMROWSKI: Okay, thank you, I have no other questions.

MR. HEWSON: I have some to follow up.

RE-EXAMINATION

BY MR. HEWSON:

Q. Is there anything on Exhibit 4 that indicates that Dr. Donahue is board certified? Does that show up anywhere in any of his reports that indicates he's board certified in any specialty?

A. No, but not everyone who is board certified says so on their letterhead, but again if I were at my home computer I could check in one minute, but there's nothing on these files that says so.

Q. My point is, you were just asking to look at the records.

A. Yeah.

Q. And there's nothing in here whether he was or not that indicates to you that Dr. Donahue is board certified?

A. That's correct.

Q. And when you checked the American Board of Medical Specialties website you found that he's not board -- or he's not listed on the board for that particular area, am I correct in that?

A. He's not listed on ABMS. Now, keep in mind that's the umbrella organization for M.D.s. Some D.O.s will get board certified on the M.D. side for various political and other reasons.

The D.O. universe has its own set of

board certifications, so it's the American Board of -- oh, of osteopathic PM&R, of osteopathic orthopedic medicine, and again I could check now if he's board certified.

And if he is, from the osteopathic side I take that as full scale as if it were on the ABMS side for an M.D. or a D.O. on the M.D. side.

Q. Sure.

A. But I just don't know.

Q. I understand. My point is, apparently we're not going to hear from Dr. Donahue himself so my question is from the documents you have there is no way of determining that, even when you did your own investigation, is that a correct statement?

A. Well, I don't know. There might have been a way back a year and a half ago for me to check the D.O. website, but I didn't know about it then.

I've done it routinely for at least a year now, but -- so I just don't know.

Q. Okay. The reports -- the report of August 19, 2010 from Dr. Donahue is not authored to any particular individual, is it?

A. It's not authored, it just says that it's a second opinion from Dr. Glowacki.

Q. From Dr. Glowacki. The report of December 14, 2010, who's that one sent to?
A. A Mr. Temrowski.
Q. And, sir, on Page 2 of your report of July 11, you found something particular in relationship to Dr. Donahue's report, did you not?
A. On July 11, sorry.
Q. Yes. On the third line of your report.
A. I said the exam recorded -- is that what you mean?
Q. Yes, sir.
A. The exam recorded the second date was identical, the physical examination, pertinent findings, was identical in verbatim fashion to the only other visit -- oh, that was the first day.

The history -- the exam on 8-19-10 was identical to 12-14-10.

Q. Identical, is that significant?
A. Well, these were done four months apart and every pertinent finding, again was word for word the same. What I said was that's a medical impossibility.

Even if someone has a ruptured disk or a pinched nerve or something, it just doesn't happen that the exam is identical even a week

apart or a couple of days apart necessarily.

So, yeah, to me that's relevant in that it's hard to lay much credibility on that examination when findings are exactly the same.

Q. Now, Dr. Zamorano, you were asked about Dr. Zamorano. Did she make a diagnosis?

A. I didn't see an actual diagnosis in her report, no.

Q. So really there's no diagnosis for you to disagree with?

A. Right.

Q. And there were some interesting issues that arose from her report relative to her charges, correct?

A. Yes.

Q. And what was your concern there?

A. Well, I just listed what she charged, for example for the EMG --

Q. Yes, sir.

A. -- she did it for the arms and legs, and her bill was $8,000. When I -- it's rarely necessary to do all four limbs for an EMG, but when I do that, and when I use the State of Michigan Work Comp Guidelines, they have a pay schedule, it's about -- if I remember right -- about $1,250, $1,250 reimbursement.

Q. For all four limbs?
A. For all four limbs, so I said it's about six or seven times what the State of Michigan would allow, you know, etc.
Q. Now, you also note that she claims there's 4 out of 5 strength throughout all four limbs. Could you tell the jury in ranking strength what 4 out of 5 means or what the general ranking system is?
A. It's 0 through 5, 5 is normal. 4 is mild to moderate weakness so just what it sounds like.

You know, I can resist -- the person can resist against me, but I can overcome them, you know, somewhat. She listed the exact same strength or weakness 4 in every muscle she tested, arms, legs.

Once again, that's a medical impossibility. That's just not the way things work and, you know, I'm not sure why she listed 4. Either -- there's a lot of possible reasons, but it's not possible what she listed.

Q. And you had a concern relative to the charges she was attempting to impose for a lumber corset, is that correct?
A. Well, yeah. She apparently dispensed a corset from her office.

Q. What did she charge for that?
A. $2,000.
Q. How does that factor in in your knowledge of what those things are supposed to be charged at?
A. From what I've seen, both off the shelf and for other invoices about 20 times, $100 or in that ballpark, a little less, a little more, but about 20 times to give somebody a corset out of your office.
Q. Are you supposed to do that? Are you supposed to provide DME out of your own office?
A. Well, people who do so would argue it's legal and it is legal in certain settings, but it's also illegal in other settings because of the potential conflict of interest in dispensing medications from your office, dispensing DME from your office or doing PT out of your office.

Any federally-funded patient, have addressed very much the medical and ethical conflict that that potentially leads to. And so it's illegal in those settings.

Q. Now, my brother counsel showed you Dr. Higginbotham's reports from July 23, 2010 and I believe his follow-up report from September 3, 2010, correct?

A. Right.
Q. There were things that you were asked basically to ignore in the findings from Dr. Higginbotham, isn't that true?
A. No, he didn't ask me to ignore them. He just didn't ask me about it.
Q. All right. Well, let me ask you about this symptom amplification issue. Do you remember discussing that? Let me show you Exhibit 6.

Do you remember discussing that in your report of July 11, 2011?
A. I believe I did, yes. Did I?
Q. Second to the last paragraph.
A. Yes.
Q. Could you take a look at the report and share with the jury what Dr. Higginbotham's concerns apparently were relative to symptom magnification?
A. Can you give me a hint where?
Q. I think -- I believe it's in the --
A. Oh, here we go. So Page 5, last paragraph, "I believe his presentation of being incapacitated to the point of requiring attendant care is symptom amplification" he says.

He appears to be capable of caring for

himself, etc.

Q. Does Dr. Higginbotham say that any attendant care should be ordered for Mr. Waskowski?

A. No, he says no.

Q. How does symptom magnification defined by Dr. Higginbotham interact, if it does, with your finding of malingering?

How do those two things correlate, if they do?

A. Well, symptom magnification is a -- if you will, a manifestation of malingering. It's one of those things where like I mentioned before, I'm going to magnify my symptom of aching because I have a cold so somebody else gets me the glass of orange juice.

But when that becomes the primary behavior and it's done in the conscious way, which my examination clearly pointed out was very conscious, that becomes a diagnosis of malingering.

Q. Now, there was discussion of epidural steroid injections as a possible diagnostic or therapeutic approach to Mr. Waskowski's complaints, is that correct?

A. That was.

Q. Could you explain to the jury what a diagnostic epidural steroid injection is as opposed to a therapeutic one, if you know the difference?

A. Well, I do and one would have a hard time finding support for the idea of a diagnostic epidural. It's an invasive procedure that carries potential risks. I mean, overall they're fairly safe. Unfortunately we're hearing about dozens of deaths from -- you know, it's not the typical epidurals with this fungus, but nonetheless potential complications or side effects.

And it really should be done, if you look at organizations that oversee or deal with this, they talk about you have to have actual radiculopathy.

Just symptoms is not enough and -- we haven't talked about this so far, but in terms of epidurals, they were never indicated in Mr. Waskowski for any stretch -- by any stretch of the medical imagination if you go by the guidelines that these organizations print, which is it has to be pinched nerve kind of pain.

At no pain -- and not just pain, not just symptoms, but there has to be some support for an actual radiculopathy, reflex or something

that's dropped or atrophy or something.

None of that ever occurred in Mr. Waskowski. Nobody ever documented an abnormal neurologic exam. So as another point, not just me but guidelines, nationally published guidelines, would disagree that epidurals were warranted.

Q. Dr. Higginbotham also suggested in that diagnostic impression that there's no evidence of acute osseous fractures or disruptions related to the accident.

Did I read that correctly?

A. Yes.

Q. Now, Dr. Higginbotham never said any of these conditions that were found were related to the automobile accident in his reports, did he?

A. Let me see the rest of it. Well, he goes on to say at the top of Page 5 he talks about the MRI findings we discussed.

Q. Yes, sir.

A. He says, "From a medical perspective, however, it does not appear to be likely or probable that these changes are related to the auto [sic] accident" so from his standpoint maybe he was saying the epidurals -- I would disagree -- but

the epidurals could be tried just because because, but he did not think those changes were related.

Q. To the automobile accident?

A. Right.

Q. Thank you. Lastly, I want to show you Exhibit 7 and ask you if Dr. Endress -- I'm sorry.

In the last paragraph on the third report from Dr. Endress, what if any findings did Dr. Endress suggest relative to the bone scan that indicated fractures?

A. He said it showed no evidence of acute fracture shoulders, ribs or spine.

Q. Was there any designation by Dr. Endress in his report that any of these conditions arose from the automobile accident?

A. Let's see if they ask about causation. I don't see -- well, you can infer from his answer to Question 3 that I was asked about before that he thinks at least something was related because Answer 3 was has he reached -- has he, Mr. Waskowski, reached pre-injury status and his answer was no, he doesn't think he has, so that tells me he was thinking that something did happen and he hadn't yet come back to baseline.

Q. Does that report tell you what it was that he thought had happened?
A. No -- well, I'm sorry, in terms of what he meant by Number 3 --
Q. Right.
A. -- Number 2 said -- Dr. Endress' answer was about the disk herniations in the neck and low back.
Q. Having reviewed those reports again with Mr. Temrowski, with myself and in your initial view, does that -- does any of this change any of your opinions relative to your ultimate diagnosis of malingering for Mr. Waskowski?
A. No, primarily because the main line of questioning was about disk herniation and, again, disk herniation takes on a very specific clinical pattern and there's nothing in any of -- certainly my exam or any other documentation by anybody else that would suggest disk herniation and those charges are chronic degenerative changes found on MRI, they're not acute.

MR. HEWSON: Thank you, sir. I have nothing else.

RE-EXAMINATION

BY MR. TEMROWSKI:
Q. I just want to clarify one thing, doctor. These

reports from Dr. Donahue that we've talked about and had marked as Exhibit 4, if my client is Mr. Waskowski and Mr. Waskowski treated with a doctor such as Dr. Donahue, would you find it unusual for me as the attorney to write to the doctor to get a report from the doctor?

MR. HEWSON: Objection, relevance. Go ahead.

A. Oh, you're asking about that it was addressed to you?

BY MR. TEMROWSKI:

Q. Right.

A. No.

Q. You don't see anything unusual about that, do you?

A. We're in the system obviously and so -- no, I don't see anything unusual.

Q. And I just want to clarify one other little thing here. Dr. Donahue's first report on Mr. Waskowski was dated August 19, 2010, right?

A. Yes.

Q. And he clearly states that on that particular day he saw Mr. Waskowski as a patient in his office?

A. Yes.

Q. When you look at the December 14 report that

Dr. Donahue wrote to me, does he -- does the doctor indicate anywhere in there that he actually saw Mr. Waskowski on December 14?

A. So you think this might just be a summary of his --

Q. Correct.

A. -- of his input so far to that date? Which would explain why the report was identical from one to the other.

Q. Exactly.

A. Yeah, it could be. He doesn't say so though and usually -- I mean, I've seen a lot of reports like this and usually it would be that this is a summary of my exam from this and such date. He didn't mention the 8-19-10 date whatsoever in here.

He says spine questionnaire 8-19-10, so if that's the case, if it was only the one examination, then -- and he's just recounting what happened before, then I'll take back my concern about the reports being verbatim from one to the other.

Q. And last but not least regarding whether or not Dr. Donahue is board certified, would we -- since we're at your office here today -- would we be

able -- because you said it would only take a second -- could we go off the record and you check that?

A. I'm not online here in the office, believe it or not.

Q. Well, let me ask you this then, doctor. If Dr. Donahue performed surgery at William Beaumont Hospital, would you expect him to be board certified?

MR. HEWSON: Objection, foundation. We're not going to hear from Dr. Donahue. Subject to that, you can answer, please.

A. Not necessarily. I mean most medical centers have standards of, you know, what they want someone to be. Some will say you have to be board certified, but I don't know what Beaumont standards are for privileges.

BY MR. TEMROWSKI:

Q. So when Mr. Hewson asked you questions about whether or not Dr. Donahue is board certified or Dr. Glowacki or Dr. Zamorano, you don't need to be, do you?

A. No, you don't need to --

Q. In order to practice.

A. You don't need to be board certified to practice

medicine, no. You need to be licensed, but not board certified.

Q. Right, and as you just stated, you don't -- some hospitals don't require that you be board certified to do surgery there, correct?

A. Right.

MR. TEMROWSKI: Thank you, I have nothing else.

RE-EXAMINATION (CONTINUED)

BY MR. HEWSON:

Q. Without board certification, there's no evaluation of the doctor by their peers as to their skill level, is that true?

A. That's correct.

MR. HEWSON: Thank you. I have nothing else.

MR. TEMROWSKI: No questions.

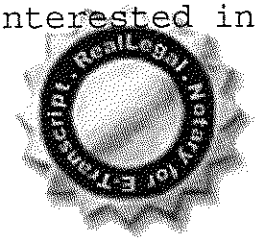
VIDEOGRAPHER: This concludes the deposition and we're going off the record at 2:47 PM.

(The deposition was concluded at 2:47 p.m., signature of the witness was not requested by counsel for the respective parties hereto)

CERTIFICATE OF NOTARY

STATE OF MICHIGAN)
) SS
COUNTY OF WAYNE)

I, DALE E. ROSE, Certified Shorthand Reporter, a Notary Public in and for the above county and state, do hereby certify that the above deposition was taken before me at the time and place hereinbefore set forth; that the witness was by me first duly sworn to testify to the truth, and nothing but the truth, that the foregoing questions asked and answers made by the witness were duly recorded by me stenographically and reduced to computer transcription; that this is a true, full and correct transcript of my stenographic notes so taken; and that I am not related to, nor of counsel to either party nor interested in the event of this cause.



DALE E. ROSE CSR-0087
Notary Public,
Wayne County, Michigan

My Commission expires: 7-15-18

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